AUTHORIZATION REQUEST FORM

Utilization Management Local Phone: (717) 370-6450
Utilization Management Toll Free Phone: (844) 540-3705
Utilization Management Fax: (717) 412-1001

Today's Date & Time:	**Member Name:**
Provider Contact Name:	**Date of Birth:**
Provider Contact Phone:	**Member ID (including any alpha prefix):**
Provider Contact Fax:	**Health Plan:**
Provider Name:	Notification Method Preference: ◯ Postal Mail ◯ Fax *Please be sure mailing address or fax number is provided.
Provider TIN:	
Provider NPI:	
Practice/Group Name:	
Provider Physical Address:	**Notes:**
Provider Mailing Address (if different):	

Requested Procedure:	**Anticipated Surgery Date:**
CPT/HCPCS or ICD Procedure Code(s):	
Diagnosis Code(s):	
Facility Setting: ◯ **Inpatient Hospital** ◯ **Outpatient / Observation** ◯ **Ambulatory Surgical Center**	
Facility Name:	**Facility Contact Name:**
Facility TIN:	**Facility Contact Phone:**
Facility NPI:	**Facility Contact Fax:**
Facility Physical Address:	**Facility Mailing Address (if different):**

Patient's Height: _____	**Patient's Weight: _____**	**Patient's BMI: _____**

Does the patient have any of the following co-morbidities? Select all that apply.

- ☐ Diabetes that requires medication or insulin (Type I or Type II)
  A1C Level: _____
- ☐ Hypertension requiring medication
- ☐ Previous cardiac event
- ☐ Congestive heart failure
- ☐ Dyspnea
- ☐ Current smoker within past 12 months
- ☐ History of severe COPD
- ☐ Dialysis
- ☐ Acute renal failure
- ☐ Ascites within past 30 days
- ☐ Steroid use for chronic condition
- ☐ Disseminated cancer
- ☐ None of the above

Patient's Activities of Daily Living (ADL) Functional status:

- ○ Independent
- ○ Partially dependent
- ○ Totally dependent

What is the patient's current health status?

- ○ Normal healthy patient
- ○ Mild or moderate disease that does not limit activity (ex: controlled HTN or DM, mild obesity)
- ○ Severe disease which limits activity (ex: controlled CHF, history of MI, uncontrolled HTN or DM)
- ○ Severe life-threatening disease (ex: symptomatic CHF or COPD, renal failure, unstable angina)

Does the patient have psychosocial and/or substance abuse issues?

- ○ Absent - no psychosocial and/or substance issues
- ○ Addressed – psychosocial and/or substance issues present but addressed

Will any of the following be used?

- ☐ Allograft
- ☐ Autograft – patient's own tissue
- ☐ BMP – Bone Morphogenetic Protein
- ☐ Stem Cells
- ☐ None of the above

If CPT 20930 is being requested, please indicate tissue type:

Vendor: _____

Name/Type of Product: _____

Will a co-surgeon or assistant be utilized?

Co-surgeon Name:_____

Co-surgeon NPI: _____

Procedure Code: _____

- ○ Orthopedic
- ○ Physician's Assistant/Nurse Practitioner
- ○ RN Surgical Assist
- ○ Other:_____
- ○ No planned co-surgeon or assistant

Other Products Intended to be Used:

Manufacturer:

Product Line:

NOTE: Please include imaging reports, surgical plan, and clinical documentation of ALL conservative therapies that have been attempted as well as the duration of each type of conservative treatment.

Physician's Signature: **Date:**